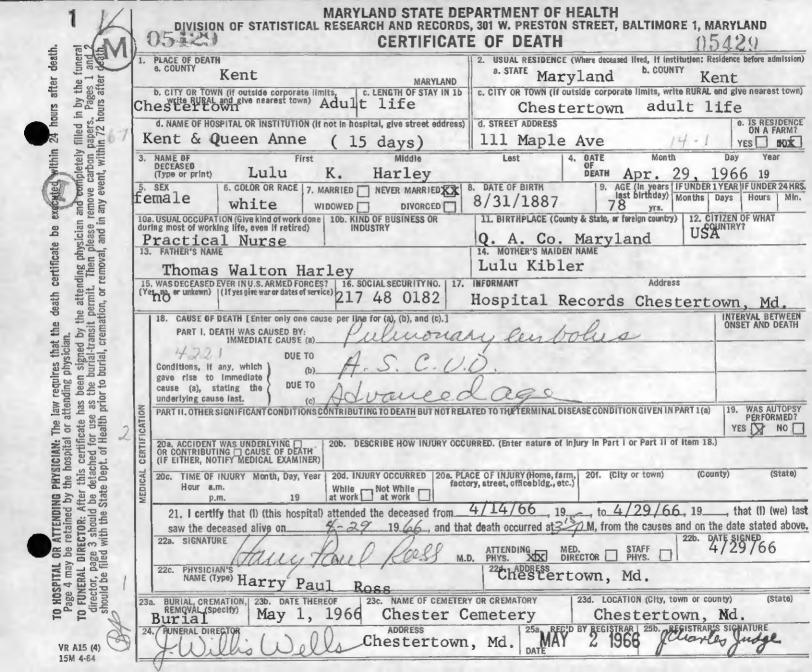
	MA DIVISION OF STATISTICAL RES	RYLAND STATE DEI			1 MADVIAND
(M)	05426		E OF DEATH	OTREET, DALTIMORE	05426
1	LACE OF DEATH COUNTY Kent	MARYLAND	2. USUAL RESIDENCE a. STATE Mary land	(Where deceased lived, If Institute b. COUNTY	Anne's
Page Is air	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	C. CITY OR TOWN (IF	outside corporate limits, write	
papers. Pagin 72 hours	Chestertown . NAME OF HOSPITAL OR INSTITUTION (if not in	2 hours hospital, give street address)	Maryde 1 d. STREET ADDRESS		6. IS RESIDENCE ON A FARM?
within .	t & Queen Anne's Hospit		R.F.D.	Box 60	YES NO X
any event, within	AME OF First ECEASED Sype or print) Belly Bay	Cloyd	Last 8. DATE OF BIRTH	4. DATE Month OF DEATH April 19. AGE (III) years [IF]	Day Year  18 19 66  UNDER 1 YEAR IIF UNDER 24 HRS
any ev	ale White Widow	TO THE MANUED TO	4/18/66		inths Days Hours Min.
	SUAL OCCUPATION (Give kind of work done 10bg most of working life, even if retired)	KIND OF BUSINESS OR INDUSTRY		inty & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Infant FATHER'S NAME		Kent Co. M. 14. MOTHER'S MAIDE	laryland EN NAME	U.S.A.
remova	Jesse Wesley Clough		Suzanne Lo		
5	no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITYNO.   17.	INFORMANT	Address	
HODE	NO	none	Hospital Re	cords	INTERVAL BETWEEN
cremation, or r	PART I. DEATH WAS CAUSED BY:	elul atalesto	ser		ONSET AND DEATH
burial, crema	1625 DUE TO 6	7. + 1.			
	onditions, if any, which (b)	Minuturell			
	ause (a), stating the DUE TO nderlying cause last.	<b>y</b>			
	ART II. OTHER SIGNIFICANT CONDITIONS CONTR	IBUTING TO DEATH BUT NOT RELA	ATED TO THE TERMINAL D	ISEASE CONDITION GIVEN IN PAI	RT1(a) 19. WAS AUTOPSY PERFORMED? YES NO
9	Oa. ACCIDENT WAS UNDERLYING (1) 20b. OR CONTRIBUTING (1) CAUSE OF DEATH OF THE CONTRIBUTION MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCU	JRRED. (Enter nature of	Injury in Part I or Part II of I	em 18.)
	Hour a.m. Wh	facto	CE OF INJURY (Home, fai ory, street, office bldg., et	m, 20f. (City or town)	(County) (State)
	21. I certify that (I) (this hospital) atte		HI 18 4 AM 19	66, to 7 AM.	19 Gothat (I) (we) las
	saw the deceased alive on 4-18 46	1966, and that	t death occurred at		d on the date stated above
	28. SIGNATURE D. Leuta	M.C	ATTENDING N	NED. STAFF PHYS.	4-20-66
1	22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		
	Dr. Robert BURIAL, CREMATION, 23b, DATE THEREOF	W. Farr	Chester	1 23d. LOCATION (City, town	or county) (State)
0	REMOVAL (Specify) 4-18-66	- Kent + (	Ducer an	no Hosp. Che	sterfour Mid
4	FUNERAL DIRECTOR	ADDRESS	25a. REC		STRAR'S SIGNATURE
	( 10 porm	aminish	alor DATE	K 2 6 1966 gc	rances frage
	-007107				

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 05427 CERTIFICATE OF DEATH hours after death. funeral and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY Pages I a b. COUNTY Kent MARYI AND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b ve carbon papers. Pag event, within 72 hours Yrs Millington Millington d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADDRESS e. IS RESIDENCE 24 ON A FARM? Pollock Nursing Home None NO P letely 3. NAME OF First Middle Last DATE Month Day Year DECEASED DF DEATH .Tohn Davis 19 66 (Type or print) April 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS Jast birthday) Col. Male and WIDOWED F DIVORCED [77] 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired R.R. Cook = 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physician and ir None COUNTRY? South Carolina 6 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova he attending | permit. Ther Giles Davis Ballard Febe 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 0 (Yes, no, er unkown) (If yes give war or dates of service) Helen Davis Millington. transit perm cremation, Maryland the 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH transi PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **D HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the Page 4 may be retained by the hospital or attending physician. gned been signed the burial-tr DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating underlying cause last. (c) as PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) WAS AUTOPS for use Health p certificate PERFORMED? YES NO K 20a. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) detached f te Dept. of 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, | 20f. (City or town) (State) (County) factory, street, office bldg., etc.) After After Hour a.m. While Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should filed with the and that death occurred at 6 4 M, from the causes and on the date stated above. saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED page DIRECTOR FUNERAL PHYSICIAN' ADDRESS director, p BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 966 Rochester Gardens a Ingleside Marvl 24/1 FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR 25b. VR A15 (4)

13 100 Lastreal. EDWINE THEODER OF collect (1) sive Me april 15 moneth Told Bill Amilian N. Seel . None English Greekland Preside today White the state of the contract of the state Medicine instantial minimum delimental local Times like in The State of the Control of the Cont

1 4		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
FOR STATE		05428 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05428					
HEALTH DEPT		PLACE OF DEATH a. CDUNTY  Kent  La. STATE  Maryland  COUNTY  MARYLAND  La. STATE  Maryland  COUNTY  MARYLAND  La. STATE  Maryland					
is necessary, o the funeral e 5 may be Department after death.		b. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town)  Chestertown (rural)  c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town)  Chestertown					
me full							
ate ate	F	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitel, give street eddress)  a.i.r. Hill Farm  e. IS RESIDENCE ON A FARM? YES \( \text{NO} \) NO					
the S		NAME DF DECEASED Ronald Hepbren Gill Last 4. DATE Month DF Dey Year Of DEATH April 9 1966					
form form	10	sex 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. DATE OF BIRTH  white VIDOWED DIVORCED 5/19/51  9. ACE (In yeers   IFUNDER 14EAR   IFUNDER 24HRS    Months Days Hours Min.					
INER: This certificate should be executed within 24 hours after death. If a tificate, writing the word "pending" in pencil in Item 18. Give Pages 1, be forwarded to the Chief Medical Examiner's Office along with form age 3 should be used as a burial-transit permit, file pages 1 and 2 with ted agent, prior to burial, cremation, or removal, and in any within		USUAL OCCUPATION (Give kind of work done industry)  10b. Kind of Business or industry  11. BirthPlace (State or foreign country)  Chestertown (Kent), Md.  12. CITIZEN OF WHAT COUNTRY?  Chestertown (Kent), Md.					
hours a land 18. ce alor a pages d in all		Father's name  Charles H. Gill Frances Long					
in 24 ho 's Office it. File val, and		. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Charles H. Gill, Chestertown, Md.					
ed within 2 n pencil in aminer's 0 t permit. I r removal,		18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]  PART 1. DEATH WAS CAUSED BY:  Fractured skull  Short					
ecute il Ex in, o		9/20 IMMEDIATE GAUSE (e) Tractor accident.					
e exe endira ial-tu natio		Conditions, if eny, which   Deceased was between a tractor & fodder wagon					
ould be executed "pending" in hief Medical Exan s a burial-transit al, cremation, or i		gave rise to immediate cause (e), stating the underlying cause last.    DUE TO hooking wagon to drawbar. Tractor backed further than than intended by Robert Fry, driver. He was struck by					
ate sho he Chi he Chi ed as burial	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED?					
the the	ICA	power take-off shaft producing the injury noted above. YES NO					
Ri. This certificate, writing forwarded to 3 should be agent, prior 1	CERTIFI	20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING COURSED. (Enter neture of injury in Part 1 or Pert II of Item 18.)  See above					
KAMINER: The certificate, uld be forw is. is. Page 3 ships gnated agent	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  10:45 xx 4/9/66 19 While at work at work of wor					
ertific be ld be Page nated	Σ	21. I certify that I took charge of the remains described above, held an Autopsy , inspection X, inquiry , and in my opinion					
		death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner					
the		CHIEF MEDICAL EXAMINER					
execute Page I for your DIRE		ACTUAL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED					
	2	EXAMINER'S Robert W. Farr, M. D. DEPUTY MEDICAL EXAMINER 4/11/66  Address (Street, city, town, or county)					
TO DEPUT please director retainer TO FUNEI of Heal	236	Burial, cremation, 23b. Date thereof 4/11/66 Chester Cemetery or crematory Chester town Kent Md.					
A.	24	FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. RECISTRAR'S SIGNATURE					
VR A15ME 3500 4-64		Marvin V. Williams Chestertown, Md. DAN PR 14 1966 Jelianles Judge.					

Comment of the Sales Bonnic Barbyon Cill E April - I was to be a first of the second , and the second or or a Date of the Pronted Long Charles of the Constant of the When the Elimin because al ... . The Lines to - ur Pedicined was between a concluse & fodest locally sufferit tradent areasist conducts a nation, and stand then intended by Montes it, delver, is ver writered . woods being grains and malaches a cold line and record The state of the s and the transfer of the transf Mary and T. Wallands. Prince our work of the control of the contro



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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05430 deoth. deoth empletely filled in by the funeral the corbon papers. Pages 1 and event, within 72 hours ofter deat 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission 1. PLACE OF DEATH o. STATE
Maryland h COUNTY o. COUNTY Kent Oueen Anne's PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours ofter MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) Ches cer town 17 days Sudlersville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HDSPITAL DR INSTITUTION (If not in haspital, give street address) Rura1 YES X NO Kent & Oueen Anne's Hospital 3 NAME OF Middle 4. DATE Manth Year First Lost Day DECEASED Elmer (Type or print) April Joseph Jennings DEATH 66 S SEX B DATE OF BIRTH 9. AGE (In years IF UNDER 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdov) Months Davs Hours WIDOWED DIVDRCED Male White 3-17-01 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during most of working life, even if retired) Labor (Elec.) U.S.A Vita Food Baltimore, Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles Joseph Jennings Florence Reathman (D) 16. SOCIAL SECURITY NO. 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? Address (Yes, no, ar unknown) ((If yes give war or dates of service) 20 No 216-09-3587 Hospital Records 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by physicion. **DUE TO** Canditians, if any, which gave 1 rise to immediate cause (o). DUF TO stating the underlying couse as the prior to Le retained by the hospital or ottending O FUNERAL DIRECTOR: After this certificote hos been 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? for use YES [ 20g. ACCIDENT WAS UNDERLYING [1] 205. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detoched 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED factory, street, affice bldg., etc.) Hour a.m. Nat While 19 at work 3-17 21. I certify that (I) (this hospital) attended the deceased fram. 19.66, to 4-3-, 19.66, that (I) (we) last ploods 1966, and that death accurred at 7/5 pM, from causes and on the date stated above. saw the deceased alive on\_ 22a. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Dr. Arthur T. Keefe Chestertown, Maryland director, should by 23d. LOCATION (City or Town) 230. BURIAL, CREMATION, 23h DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) BUYALISpecity) Chestertown, Md. 4/5/66 Chester Cem. 25b. REGISTRAR'S SIGNATURE 250. REC'D BY REGISTRAR **ADDRESS** 24. FUNERAL DIRECTOR Chestertown, Md VR A15 (4) 20 M 1/66

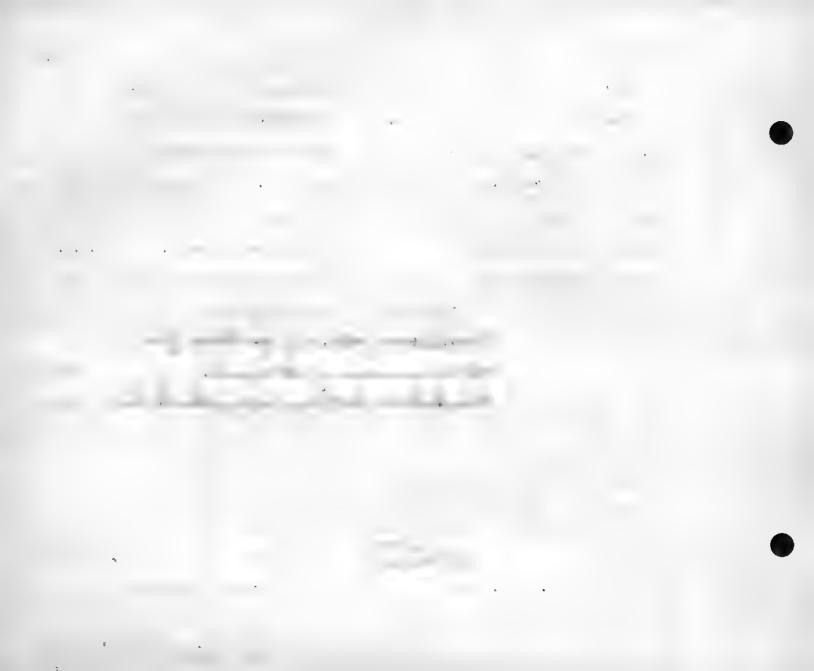
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY a. STATE b. COUNTY this certificate has been signed by the attending physician and completely filled in by the f detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 is Dept. of Health prior to burial, cremation, or removal, and in any enert, within 72 hours after Maryland Kent Kent MARYLAND b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) 18 days Chestertown Millington d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? Kent & Oueen Anne's Hospital YES NO X executed within 3. NAME OF Month Middle Last DATE DECEASED (Type or print) LaPorte DEATH =Linda 1966 Catherine April AGE (In years | IF UNDER 1 YEAR | FUNDER 24 HRS. | last birthday) | Months | Days | Hours | Min. 6. COLOR OR RACE | 7. MARRIED | X NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9. Female White WIDOWED | DIVORGED T 1 - 18 - 1353 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT PHYSICIAN: The law requires that the death certificate be the hospital or attending physician. Own Home Housewife U.S.A Kent Co., Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Alfred Thomas Foraker M Linda Frances McNatt 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO. (Yes, no. or unkown) (If yes give war or dates of service) 214-32-7169 Hospital Records INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating underlying cause last. CERTIFICATION WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) > NA K Kereci, um NOVE YES 20a. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (Clty or town) (County) (State) TO FUNERAL DIRECTOR: After t director, page 3 should be de should be filed with the State Hour a.m. While Not While be retained by at work at work 19 66 to 3-24-4-11- 19 66, that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from 1966... and that death occurred at 7:24 M, from the causes and on the date stated above. 4-11saw the deceased alive on... 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. Page 4 may t M.D. DIRECTOR ADDRESS 22c. PHYSICIAN'S 22d. NAME (Type) Dr. Arthur T. Keefe Chestertown, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) 23b. DATE THEREOF BURIAL, CREMATION, REMOVAL (Specify)
Burial Kent Co; Md. Millington Cemetery Millington, April, 14, 1966 25b. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR I FUNERAL DIRECTOR **ADDRESS** VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death death, filled in by the funeral popers Pages I and 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased used, if institution, Residence before admission) o. COUNTY o STATE 6 COUNTY MARYLAND Kent Maryland Maryland Kent

C CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELENGTH OF STAY IN 15. bon popers Page within 72 hours a **LANGUE KUMM** 27 days Chestertown Chestertown d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? 307 Washington Avenue/ YES T NO T Kent & Oueen Anne's Hospital 3 NAME OF Middle 4 DATE First Lost Month Dov Year DECEASED Frederick Livingood, Sr. emove cont (Type or print) George DEATH April 25 19 66 SE UNDER 1 YEAR S SEX 6 COLOR OR RACE B. DATE OF BIRTH AGE ( n years IF UNDER 24 HRS 7 MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours X White WIDOWED DIVORCED Male 9-19-1893 10o USUAL OCCUPATION (Give kind of work done TOB KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY the attending physicion sit permit. Then pleose Retired College Professor Jefferson Co. Penna II.S.A 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Samuel Kline Liwingood (D) Rebecca Marguerite Schaeffer (D) 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. permit. (Yes, no, ar unknown) [[]] yes give war or dates of service) 214-32-0974 No Hospital Records 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART ! DEATH WAS CAUSED BY. INTERVAL BETWEEN signed by the buriol-tronsit p ONSET AND DEATH IMMEDIATE CAUSE (a) be retained by the hospital or ottending physician. buriol, ( Conditions, if any, which gave rise to immediate couse (a) DUE TO stating the underlying couse as the prior to t Page 4 may be retained by the hospital or ottending O FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED PERFORMED? use MEDICAL CERTIFICATION Health NO CA ٥ 200 ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) Hour o.m. Not While factory, street, affice bldg., etc.) of work of work e 4-25 21. I certify that (1) (this hospital) attended the deceased fram. 3-29 1966 that (1) (we) last 19**66** to saw the deceased alive an\_ 4-25 19 66, and that death accurred at 45/0M, from causes and on the date stated above. 22o. SIGNATURE DATE SIGNED **ATTENDING** STAFF DIRECTOR PHYS director, page should be filed 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) Dr. A. C. Dick Chestertown, Maryland 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL, CREMATION, (County) (Stote) 4/28/1966 Mt. Hope Cemetery Myerstown, Penna. 25b REGISTRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Chestertown, Md.



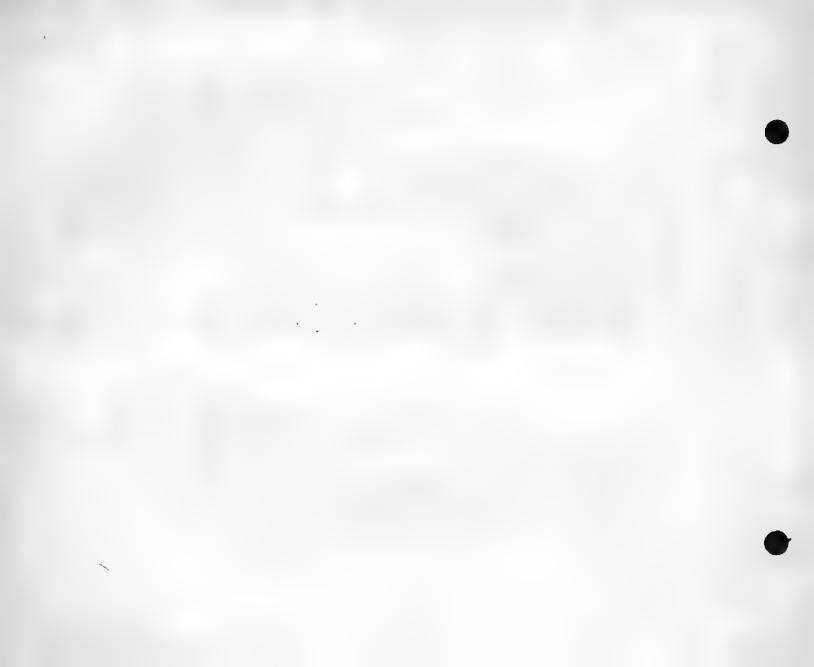
1(M)	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
# 20 M	05433 CERTIFICATE OF DEATH
hours after death. d in by the funeral fs. Pages 1 and 2 f hours after death	1. PLACE OF DEATH  a. COUNTY  A. STATE  MARYIAND  2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)  a. STATE  MARYIAND  D. COUNTY  OLDER 1. AND  AND  AND  AND  AND  AND  AND  AND
executed within 24 hours after and completely filled in by the fremove carbin papers. Pages 1 n any brem, within 72 hours after	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  write RURAL and give nearest town)
24 hour apers.	d. NAME OF HOSPITAL OR INSTITUTION (If not In hospital, give street address)  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?
hin 2	3. NAME OF FIRST Middle C Last 4. DATE Month Day Year
of with	(Type or print) ERNEST JAMES ROTHWELL DEATH APRIL 18 1966
and co	MALE WHITE WIDOWED DIVORCED JAIV. 8-1894 72 yrs. Months Oays Hours Min.
be e ician ease r	10e. USUAL OCCUPATION (Give kind of work done of the line of the l
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h cert tendin iit. Th	HRTHUR D, NOTHWELL ELIZABETH COWELL  15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  (Yes, no, or unknown) ((If yes give war or dates of service)
the at the at t pern ation,	215-36-8735A HLFRED NOTHWELL - CENTROVILLE  18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]    INTERVAL BETWEEN
at the sian. sd by transit crem	PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) ACULTE MUYO CARDIAL INFARCTION  ONSET AND DEATH
ires the hysic signs signs burial.	Conditions, if any, which (b) ARTERIOSCIEROTIC CARDIOUASCULAR
requirements been so the ior to	gave rise to immediate cause (a), stating the DUE TO underlying cause last. (c)
The law requires that the death certificate be executed within or attending physician. Completely cate has been signed by the attending physician and completely r use as the burial-transit permit. Then please remove carbyn eaith prior to burial, cremation, or removal, and in any went, with	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTOPSY PERFORMED?  YES NO
TO HESPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending mysician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and director, page 3 should be detached for use as the burial-transit permit. Then please remoshould be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.)  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
ATENDING PHYSICIAN: retained by the hospital CTOR. After this certific should be detached for with the State Dept. of H	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED According to the factory, street, officebidg., etc.)  20f. (City or town) (County) (State)
NDING red by * After ald be he Stat	21. I certify that (I) (this hospital) attended the deceased from 10-23, 1963, to 4-18, 1965, that (I) (**) last
ATTENDIII retained ECTOR: A: 3 should with the S	saw the deceased alive on 18 19 66, and that death occurred at 97 M, from the causes and on the date stated above.  22a. SIGNATURE / 22b. DATE SIGNED
AL OR nay be yage 3 page 3 filed v	22c, PHYSICIAN'S (1) PHYS. ATTENDING MED. STAFF   4-21-66
TO HESPITAL Page 4 may TO FUNERAL I director, pag should be fill	NAME (Type) HARRY PALL KOSS 203N GLOON, CHESTERTOWN, MO
TO Page dir.	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)  BURIAL APRIL 21 CHESTER FIELD CENTREVILLE MIP.
VR A15 (4)	24. FÜNERAL DIRECTOR STARE - CHURCH HILL MD DAAPR 25 1966 ACIONES JUSSE
13M 4*04 X	



-4- 1 (M)	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND				
FOR STATE	05434 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05434				
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY A. COUNTY A. STATE B. COUNTY A. STATE B. COUNTY MARYLAND MARYLAND MARYLAND MARYLAND  2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY MARYLAND MARYLAND MARYLAND MARYLAND				
Flay is necessary, 13 to the funeral Page 5 may be State Department ours after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town)  MARYLAND  MARYLAND  MARYLAND  MARYLAND  C. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town)				
ecess may may	Chestertown 5 hrs. Rural - Rock Hall				
is no the to the See 5 aft	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress)  Kent & Queen Anne 8				
Adelay is to Page State hours	3. NAME OF First Middle Last 4. DATE Month Day Year				
The Man	OF (Type or print) Shirley Elizabeth Sisco DEATH 4 29 19 66				
ith. If a form P form P within	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED X 8. DATE OF BIRTH 9. AGE (In years   FUNDER 1 YEAR   IF UNDER 24 HRS. last birthdey) Months   Days   Hours   Min.				
Page h fo	Female Negro WIDOWED DIVORCED 10-31-35 30 yrs.   10-3 USUAL OCCUPATION (Give kind of work done   10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT				
ive Paline Palin	during most of working life, even if retired) INDUSTRY COUNTRY?				
ours after n 18. G s along pages 1 in any	Teacher Education   Maryland   USA  13. FATHER'S NAME   14. MOTHER'S MAIDEN NAME				
tem 1	Randolph Sisco Mozella Lewis				
7 5 F.	15. WAS DECEASED EYER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service)				
within pencil miner's	No Hospital Records  18. CAUSE OF DEATH [Enter only one cause per like for (a), (b), and (c).]				
xami po	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Air embolisam 1 hr.				
uld be executed "pending" in "pending" in strong but a burjal-transit cremation, or strong st	754 X DUE TO				
be expend hedio	Conditions, if any, which gave rise to immediate (b)   Unknown				
a bi	cause (a), stating the DUE TO underlying cause last. (c)				
ficate shou the word o the Chie used as a to burlat,	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY				
the	Under anesthesia for laparotomy 3 hrs.  YES NO 1  20a. EXTERNAL CAUSE WAS 1 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.)				
AL EXAMINER. This certificate should be executed within 24 hours after death. If a the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, should be forwarded to the Chief Medical Examiner's Office along with form r files.  CTOR: Page 3 should be used as a burial-transit perror. The pages 1 and 2 with designated agent, prior to burial, cremation, or removement in any event within	B PRIMARY OF CONTRIBUTING CAUSE OF DEATH.				
R: This ate, wr forward 3 shoul agent,	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  While of work of two by the etwork of two by th				
tif Canal					
the certification of the certi	21. I certify that took tharge of the remains described above, held an Autopsy, inspection, inquiry, and in my opinion death resulted for: Matural causes, Accident, Suicide, Homicide, Undetermined manner				
EDICAL the cute the age 4 sh r your fill DIRECTO	CHIEF MEDICAL EXAMINER				
ry Medic execute Page 4 i for you tal diss	ACTUAL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER X				
o DEPUTY MEDICAL please execute the director. Page 4 s retained for your fi o FUNERAL DIRECTO of Health or its de	EXAMINER'S NAME (Type) 0. S. Gulbrandsen, M.D. Address (Street, city, town, or county) 5-2-66				
o DEPUTY please et director. retained O FUNERA of Health	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (state)				
E E E E	24. FUNERAL DIRECTOR  ADDRESS				
VR A15ME 3500 4-64	Bemelt walk, ChasTerTown MAY 5 1966 Icharles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH UD-450 funeral and 2 death death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY Kent been signed by the attending physician and completely filled in by the f the burial-transit permit. Then please remove carbon papers. Pages 1 or to burial, cremation, or removal, and in any event, within 72 hours after Maryland Kent MARYLANO CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Worton HOURS Worton adullt life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6. IS RESIDENCE ON A FARM? d. STREET ADORESS At Home YES [ NOXX executed within 3. NAME OF First MIddle DATE Month Year Last DECEASED Irving F. Smith 4/2/66 (Type or print) DEATH 19 AGE (in years | IFUNDER 1 YEAR IF UNDER 24 HRS. last birthday) | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED XXINEVER MARRIED male white 1897 68 WIDOWED DIVORCED 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done | 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) The law requires that the death certificate be during most of working life, even if retired) INDUSTRY Cattle Buyer Dealer Queen Anne Co. Md. USA 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME John C. Smith Mary E. Taylor 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) 17. INFORMANT Address 16. SOCIAL SECURITY NO. 16 5200 no Mrs. Mabel Smith Worton. Md. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: Bronchopneumonia left lower lobe INTERVAL BETWEEN HITEG THE TRAVE the hospital or attending physician. IMMEDIATE CAUSE (a) days DUE TO infection Upper respiratory weeks Conditions, if any, which (b) gave rise to immediate as the prior to DUE TO cause (a), stating the this certificate has be detached for use as the Dept. of Health prior underlying cause last. (c) WAS AUTOPSY PERFORMED? CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES NO ] 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) PHYSICIAN: State Dept. c Page 4 may be retained by the ho TO FUNERAL DIRECTOR. After this director, page 3 should be detach should be filed with the State Depi MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not While ATTENDING at work L at work 1966 66 21. I certify that (I) (this hospital), attended the deceased from 19 and that death occurred at ## M. from the causes and on the date stated above. saw the deceased alive on 22b. OATE SIGNEO 22a. SIGNATURE ATTENDING XX MED. STAFF PHYS. M.D. ADDRESS Chestertown, Md. PHYSICIAN'S 22d. 22c. NAME (Type) Robert BURIAL, CREMATION, REMOVAL (Specify) BURIAL NAME OF CEMETERY OR CREMATORY (State) DATE THEREOF 23d. LOCATION (City, town or county) 23b. /66 Chestertow Cem Chestertown 25b. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR FUNERAL DIRECTOR Chestertownm Md 1966 VR A15 (4) 15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death deoth inpletely filled in by the funeral e corban papers. Pages 1 and PLACE OF OFATH 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before odmission) p. COUNTY o. STATE b. COUNTY Kent MARYLAND Maryland Kant b. (ITY OR TOWN (If outside corporate mits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 15 van papers. Pag within 72 hours Chestertown 16 days Rock Hall d. NAME OF HOSPITAL OR INSTITUTION (IF not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Kent & Oueen Anne's Hospital YES NO RE 3 NAME OF Midd e First 4. OATE Lost Month Oov Year DECEASED Walter (Type or print) Weslev Stevens April 21 19 66 DEATH S SEX DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF JINDER 24 HRS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED birthdoy) Months Dovs Hours Male White WIDOWED DIVORCED 10-3-80 ease 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if refixed)
Retired Painter INDUSTRY U.S.A. ond physicion Kent Co., Md. 13 FATHER'S NAME 14. MOTHER'S MAJOEN NAME or removal, ottending phys nermit. Then p Wesley Stevens (D Emily Ashley WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dotes of service 218-18-7778A Hospital Records No CAUSE OF CEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the c burial-transit p buriol, crematia ONSET AND DEATH PART 1. OEATH WAS CAUSED BY. 1 CONCLUMEN IMMEDIATE CAUSE (o) 163X OUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stating the underlying couse os the prior to l TO HOSPITAL OR ATTENDING PHYSICIAN: the law re Poge 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate hos been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? CERTIFICATION YES X NO Por 200 ACC DENT WAS UNDERLYING [ 20b, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF CEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 180 20e. PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (City or town) (County) (Stote) foctory, street, office bldg., etc.) Hour o.m. Not While of work of work 1966 4/21/ 19 66, that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased fram. 4/5/ ta. 19.66, and that death accurred at 130 saw the deceased alive an-4/21 P.M. fram causes and an the date stated above. 22m SIGNATURE 22b DATE SIGNED **ATTENDING** M.D. PHYS DIRECTOR PHYS. 22d ADDRESS 22c. PHYSICIAN SA NAME (Type) Dr. Harry P. Ross Chestertown, Maryland director, should be 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) 23o. BURIAL, CREMATION, (County) REMOVAL (Specify) 250. REC'D BY REGISTRAR 256 April 24 Buria Wesley Chanel **AODRESS** FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Church Hill

2\* "]

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAN	lD O			
05437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH U543	1			
1. PLACE OF DEATH a. COUNTY Kent  2. USUAL RESIDENCE (Where deceased lived, if institution; Residence b a. STATE MARYLAND  AMARYLAND  2. USUAL RESIDENCE (Where deceased lived, if institution; Residence b a. STATE MARYLAND  AMARYLAND	/			
write RURAL and give nearest town)	nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  d. STREET ADDRESS  0.	S NO X			
3. NAME OF First Middle Last 4. DATE Month Day OF CEASED	Year 19 66			
5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED     8. DATE OF BIRTH   9. AGE (In years list Under 1 YEAR)     Months   Deys	Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10b. KIND OF BUSINESS OR iNDUSTRY  Various  11. BIRTHPLACE (State or foreign country)  Kent Co. Mary land  12. CITIZEN O	FWHAT			
13. FATHER'S NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  (Yes, no, or unknown) (If yes give war or dates of service)  Market 10. But				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	VAL BETWEEN T AND DEATH MOWN			
Gonditions, If any, which gave rise to immediate Dis TO	ek			
underlying cause last. ) (c)	WAS AUTOPSY PERFORMED?			
Previous tuberculosis, quiescent 0072  20a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)				
	(Stete)			
21. I certify that tapk charge of the remains described above, held an Autopsy, Inspection, inquiry, and	In my opinion			
ACTUAL CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER 22.	DATE SEGNED			
EXAMINER'S NAME (Type) O. S. Gulbrandsen, M.D. Address (Street, city, town, or county)	-2-66			
Burial 5-2-1900 Sharptown Cemetery in the national ass projectable close	(State)			
Lasterland Date Charles & Date AND 5 1966 Filiarles &	udge			
	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  1. PLACE OF DEATH 1. PLACE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decawed lived, If institutions residence by Country Kent 2. USUAL RESIDENCE (Where decawed lived, If institutions residence by Country Kent 3. CITY OR TOWN (if outside corporate limits, When the Country Kent 4. CITY OR TOWN (if outside corporate limits, With RUBBLA, and give nebroses town) 3. CITY OR TOWN (if outside corporate limits, With RUBBLA, and give nebroses town) 4. A NAME OF HOSEITAL OR HISTITUTION (if not in hospital, give street address) 4. A NAME OF HOSEITAL OR HISTITUTION (if not in hospital, give street address) 4. STREET ADDRESS 4. STREET ADDRESS 5. SEX 5. COLORS OR RACE   THOMAS   Middle   Last   4. DATE   Months   MONTHS   MONTHS   MONTHS   MONTHS   MONTHS   MONTHS   MON			

Carpendado es servicios de constitución de con - c • A STATE OF THE STA A SECTION OF THE PROPERTY OF T A CONTRACT OF THE STATE OF THE 

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. CDUNTY Kent b. CDUNTY Maryland Kent completely filled in by the 1 ve carbon papers. Pages 1 event, within 72 hours after MARYLAND b. CITY DR TDWN (If outside corporate limits. c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b Chestertown (Pire Chestertown Rural lifetime (Rural) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? Fairlee Fairlee NOT2 YES law requires that the death certificate be executed within 3. NAME DE Tilden B. DATE Willson Last Month DECEASED 66 Apr. (Type or print) DEATH 19 5. SEX 6. COLOR DR RACE DATE OF BIRTH last birthday) Months i AGE (In years | IFUNDER 1 YEAR) IFUNDER 24 HRS. attending physician and corrmit. Then please, remove n, or removal, and that 7. MARRIED X NEVER MARRIED Hours Male July 20. white 1897 WIDDWED [ DIVORCED [ 10a, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? Kent Co. Maryland Employee USA Grain & feed mill 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Alice Sappington Neal Willson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? been signed by the attend the burial-transit permit. In to burial, cremation, or re 16. SOCIAL SECURITY NO. 17. INFORMANT Address Fairlee (Yes, no, or unkown) (If yes give war or dates of service) Chestertown, Md. 218 20 8152 Willson Hester 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN DNSET AND DEATH PART I. DEATH WAS CAUSED BY: PHYSICIAN: The law requires that to the hospital or attending physician, IMMEDIATE CAUSE (a) 0 DUE TD Conditions, if any, which gave rise to immediate DUE TD (a), stating as th underlying cause last. (c) this certificate has CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY for use PERFORMED? YES ND DESCRIBE HOW INJURY DCCURRED, (Enter nature of Injury in Pert 1 or Part 1) of Item 18.) 20a. ACCIDENT WAS UNDERLYING [ jo DR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) detached be detacher State Dept. ( MEDICAL TIME DF INJURY Month, Day, Year 20d. INJURY DCCURRED | 2De. PLACE DF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. After Not While ATTENDING at work at work TO HOSPITATION TO FULL.

Page 4 may be recommended to the second of the should retained the 21. I certify that (I) (this hospital) attended the deceased from 1 3fam, from the causes and on the date stated above. saw the deceased alive on and that death occurred at. 22a, CSIGNATURE 22b. DATE SIGNED 4/15/66 ATTENDING X DIRECTOR M.D. PHYS. PHYS. 22d. ADDRESS **PHYSICIAN'S** NAME (Type) Norbert C Nitsch Rock Hall 23c. NAME DF CEMETERY OR CREMATORY BURIAL, CREMATION, 23b. DATE THEREDE 23d. LDCATION (City, town or county) (State) REMOVAL (Specify)
Burial 17/66 St. Paul Cem. Chestertown, Md. nr FUNERAL DIRECTOR 24. ADDRESS REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Chestertown, Md. 1966 VR A15 (4) 15M 4-64

